*Chapter 5*

# Interpreting and Responding to Expressions of Mental Pain: The Inner and Outer Dialogues of the Mental Health Nurse

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## Abstract

The experience and expression of mental pain can be interpreted in various ways by the mental health nurse and the client during therapeutic interaction. This chapter explores how meanings of mental distress are configured through dialogue between and within the mental health nurse and the person in care. Here, the authors follow Bahktin's (1981) thesis that meaning making is a dialogical activity, arrived at through engagement with one's own internal voices and available dialogues and discouses in the surrounding context. Thus the nurses's understanding or sense making of expressions of mental pain emerges from the interaction between inner (personal, embodied) and outer (professional / therapeutic, social) dialogues. These internal and external 'voices' inevitably influence the nurse's engagement with the client; where these are unquestioned and congruent, the nurse enters into therapeutic engagement with a sense of clarity and purpose and when these dialogues are at variance, the nurse encounters confusion as s / he struggles to find a meaningful interpretation of events so that s / he can engage purposefully with the person in care. The authors ague that while congruent dialogues may facilitate spontaneous knowing and acting, unquestioned interpretations can become habituated knowledge constructions, employing and sustaining professional monologues that dominate the communication process and suppress possible alternative voicings of mental distress. In this chapter we are interested in troubling dialogues in mental health interactions and interventions. We suggest that when inner / outer voices that are perhaps conflictual and somewhat confusing, are met with open curiosity, this approach can promote opportunities for new and transformational dialogue. Further, using vignettes

from teaching and research contexts, we offer two interlinked strategies for purposefully engaging with contending dialogues and developing communication about mental pain, thereby enhancing the therapeutic relationship between the nurse and person in care.

## Introduction

The experiences and needs of people encountering mental health problems can be understood in different ways by the mental health, depending on a number of influences. These include, in addition to the unique nature of the person's story being presented, the nurse's own internal beliefs and perceptions regarding people with mental health issues and her / his experiences of interacting with this population (England 2007, Munro and Baker 2007). The nurse's understandings and responses are also influenced by her / his external social and professional environments where there are a range of ways of perceiving and treating people who are in mental distress.

Sense making is a process that emerges from the interaction between such personal, social and professional dialogues (Bakhtin 1981). When these dialogues are congruent the nurse enters into communication with clarity and purpose. However, sometimes it is difficult to simultaneously integrate conflicting internal and external perspectives (for example; those of the nurse, the person in care, the profession and society) and the nurse struggles to know how to interpret, in a meaningful way, the stories and expressions of mental distress that are presented. While congruent unexamined dialogues may facilitate spontaneous knowing and acting, they can develop into and sustain professional monologues that dominate the communication process, suppressing alternative possibilities of understanding and engaging with mental distress. On the other hand conflicting dialogues can lead to a struggle to integrate and move forward in communication, nevertheless, their presence offers each person in the interaction the opportunity for transformation and development of understandings. The nurse is challenged to configure these multiple perspectives in self and environment so that she can make sense of situations and find ways of engaging in therapeutic interaction. It is through the struggle to integrate these dialogues that the nurse enters into meaningful engagement with the person in care.

In this chapter, using case vignettes from teaching and research in therapeutic contexts, the authors explore how the mental health nurse attempts to make sense of the experiences of mental pain narrated by people in her / his care. Two interlinked strategies are then suggested for using these dialogues to develop communication about mental pain, thereby enhancing the therapeutic relationship

between the nurse and patient. Through making some of these dialogues visible and audible, we hope to encourage mental health nurses to examine their own constructions regarding the nature of peoples' experiences of mental pain and to explore helpful ways of engaging with people in these situations. Engaging with multiple perspectives, particularly in a context where certain discourses are privileged, can be challenging. However we argue that when internal and external dialogues within the nurse and her / his environment interact, it is not just productive, but is essential to a therapeutic relationship and that when these voices are silenced, opportunities for transformative undertandings are missed and therapeutic impasse can occur in the relationship (Rober 1999).

The authors propose two interlinked communication strategies for engaging with the tensions between apparently conflicting dialogues, the use of which can lead to transformative learning and unanticipated communicative opportunities. These approaches include cultivating a disposition of curiosity (Cecchin 1987) and creating dialogic space (Anderson & Goolishian 1992).

**Meaning Making through Dialogue**

Part of being human involves interaction with a complex social and relational environment. We are embedded in a multi-vocal, pluralistic milieu and through our engagement we encounter experiences that are satisfying, troubling, limiting and enlightening. We constantly strive to make sense of these multi-dimensional experiences in order to create meaningful accounts of our worlds and our places therein (Mishler 2004). It is argued that we organise our experiences into mental stories about ourselves and thus construct narratives of our lives through time (Bruner 1987, Ricoeur 1991). In this process, often confusing impressions and happenings are configured into life episodes that are in keeping with other prevailing themes of an overall narrative thread. This meaning making is dialogical in nature as we look to available cultural and social understandings and beliefs to help us construct our sense of self and our experiences within a given culture. Bakhtin (1981) refers to the process of configuring and making sense of these inner and outer dialogues of the self as the "orchestration of voices" or "self authoring." He suggests that there is an interplay between the embodied and the social elements of the self, between intimate discourses, inner speaking and bodily practices formed in the past and the discourses and practices to which people are exposed, in their social environments, in the present.

Mental illness and / or trauma can bring about a break in one's narrative thread as the person's personal and social construction of self is challenged by

experiences that are difficult to incorporate into ones' existing narrative structure (Crossley 2000). These experiences fall outside the persons expectations of themselves and represent "biographical disruption" (Sandelowski 1994) or "narrative wreckage" (Frank 1995). As a response to the interruption, people attempt to incorporate this new phenomenon into the narrative of self by reconfiguring or re-storying their lives to accommodate it. Invariably, available cultural explanations are called upon to help in this sense making process.

People who experience mental health issues and people who care for them operate within this landscape of dialogical meaning making and identity construction through cultural stories and self stories. In the same way that the experience of altered mental state needs to be configured into a coherent sense of self for the person experiencing this phenomenon, the experience of being a nurse needs to be storied into a meaningful sense of self and purpose as a professional. In these endeavours, many disparate voices and possible ways of knowing and being resonate from within and around the mental health nurse and the other(s) in the therapeutic encounter. As Mishler (2004 p118) argues "each person has multiple perspectives on the same event, and the one that comes into play depends on variations in contexts, audiences and intentions, that is, how one positions oneself within that set of circumstances."

### Dialogues and Discourses at Play for Mental Health Nurses

There are competeting professional and social discourses about how the mental health nurse should interpret and engage with the experieces of those in mental pain. Some publicly declared imperatives suggest that the nurse should be objective, empirical and able to detach from the influences of personal bias and cultural stereotype (Koh 1999, Hawthorne and Yurkovich 2002). However, it is also acknowledged that individuals develop in environments that shape their values and beliefs and that they interpret and process experiences in many different ways. Crowe (1998 p87) suggests that:

> "The personal and professional values of mental health nurses, their beliefs about human nature, their educational and experiential background, their emotional experiences and modes of expression, and the way they perceive the self in relation to others all influence the fundamental mental health nursing skill – the therapeutic use of self in the nurse patient relationship."

The latter perspective acknowledges how multiple factors influence the nurse's perception of mental distress and her / his beliefs as to how (or whether)

people with mental health issues can be helped.  The nurse's personal and cultural experiences and perceptions come into contact with professional belief systems as s / he navigates professional socialisation processes in nursing and healthcare cultures.  The nurse looks to this socially sanctioned knowledge as a means of configuring her / his own myriad impressions of what it may mean to have mental health problems and what it may mean to be a nurse (Stickley and Timmons 2007).  In this way, the nurse incorporates prevailing discourses into her own meaning making and narrative of self.  According to Crowe (2000 p962); "particular types of knowledge and ways of acting are sanctioned by the nursing culture in order to ensure its continued existence and to reproduce the existing social order."  One example of a type of knowledge sanctioned by nursing culture is the biomedical construction of mental distress.  Within this framework mental dis-order is seen as indicative of disease or mental illness and therefore amenable to medically influenced treatments.  Experiences of mental distress are grouped into sets of symptoms which are viewed as characteristic of various types of mental illness (Collier 2008).  Acceptance of these classifications of normality and abnormality means that biomedical explanations become a dominant discourse.  Dominant discourses function to impose order on diverse phenomena; however the emphasis on homogeneity can mean that individual perceptions and personal knowledge of mental distress are marginalized and subsumed into a monologue that claims to explain and categorise all experiences of mental dis-order (Sakayls 2000, Walsh et al 2008).  Within mental health nursing, privileging of biomedical discourse can dominate therapeutic practice and prescribe how experiences of mental pain are to be constructed and understood (Harper 1994, Crowe and O Malley 2006)**.**

The literature also highlights how discourses of gender dominate and shape both socialization in nursing and the construction of meanings of mental distress (Evans, 2004).  Nurses, as a predominately female profession, are expected to embody "womanly" attributes of caring and subservience within a healthcare system that is patriarchal in nature (Fealy 2004).  In this context, many nurses argue, individual women's voices and ways of knowing both as nurses and people with mental health problems are marginalized (Stoppard 1997).  In relation to the influence of gendered discourse in ascribing meaning to women's mental distress, Busfield (1996 p117) states:

> **"**Since gender is such a key feature of social relations and a major dimension of social difference, gender inevitably features in the constructions of mental disorder."

The causes and experiences of mental distress vary for each individual, however women's experiences of mental pain are often categorized using parameters that reflect male dominated (phallocentric) assumptions, reasoning and language (Harden 2000, Warne and McAndrew 2007). For example, Sayce (2000 p110) claims that including pre-menstrual disorder into the criteria in the Diagnostic and Statistical Manual of Mental Disorders subjugated other experiences and meanings of mental distress among women by creating a "syndrome" that "made half a million more women pathological at a stroke." This privileged set of beliefs has implications in relation to how the nurse positions self as gendered and how s / he hears and interprets the voices and stories of female and male persons in interaction (Munro and Baker 2007). Similarly, the influences of race, culture and class identities are seen as inherent in the formulation and expression of meaning (Fernando 1991, Sandelowski 1994, Hinton and Levkoff 1999). Therefore, just as patriarchal gender relations can constrain female meanings, so Western assumptions about normality can silence alternative interpretations from service users and nurses from other cultures.

The following vignette from an education context in an Irish university, encountered by one of the authors, highlights the difficulties inherent in appropriating dominant discourses as the only means of interpreting experiences. The scenario described occurred among a cohort of undergraduate mental health nursing students who were using role play to evoke and explore possible experiences of mental distress and therapeutic responses. One group comprised of four African female students who had chosen "depression" as their exploratory theme. The group improvised a situation where a woman experienced, in their words, "deep sadness" following the birth of her baby. Thus a scenario was enacted where the sad woman (student A) was visited in her home by three neighbours (students B, C, and D). The neighbours brought baskets of food, tidied the house and sat with the sad woman conversing about local events and making practical arrangements for sharing the care of her children while she was sad. The woman sometimes joined in these conversations, sometimes not, but the conversations continued regardless. The woman was not the main subject of the conversation and no-one directly focused on her state of sadness. However, this was acknowledged in a pragmatically supportive way. There was no 'resolution' to the students' scenario and one felt that they would have continued talking for a lengthy period were it not for time constraints.

This dramatic re-presentation stimulated much debate and discussion. Questions were raised such as: "Where was the mental health intervention? Would these 'friends' not consider referring this woman, who probably had a diagnosis of post-natal depression, to a mental health practitioner? Perhaps she

needed a full psychiatric assessment, may be suicidal or may harm the baby? Perhaps she required admission to hospital?" The African women explained that such responses would not occur in their culture, but neighbours, family and friends would provide support. This fuelled further questions: "Was that because it was a poor country? Was support provided by well meaning but unskilled networks because there were few statutory mental health services in place?" The students replied that the woman's sadness would not be seen as something that was appropriate for medical treatment, but rather this sadness had a spiritual cause and the woman required spiritual healing. This different perspective lead to further debate, such as: "What about treatment of depression? Don't you have depressed people in psychiatric hospitals?" The African nurses explained further that in their country the term 'depression' is not used, instead the woman's problem is called 'kufungisisa' which means "thinking too much," while psychiatric hospitals are for "people who are out of control."

The students in this class had studied, practiced and discussed mental health nursing together for two years, yet this was the first time that their very different perspectives and cultural backgrounds regarding the meaning of mental illness and 'appropriate' care had been shared among the group. Why was this? The African students, although a distinct cohort within the larger group, had submerged themselves into Western constructions of mental distress based on biomedical paradigms, classifications and language, a "slipping" also observed by Stickley and Timmons (2007), while their unexpressed experiences, beliefs and understandings were something other. They had never disclosed these perceptions to the wider student group as they felt they were somehow alien, incorrect or would not be useful or appreciated within their current learning context. Many of the Western students were unaware of the different perspectives of their colleagues and had presumed consensus of attitudes and beliefs in the class based largely on biomedical principles. When the facilitator considered this matter she realized that the curriculum and teaching methods supported and indeed fostered this homogeneity, a view echoed by Chevannes (2002) and Purden (2005). The students' presentation stimulated inquiry, challenged taken for granted perceptions and helped other students in the class to articulate and discuss some of their own experiences and beliefs which had hitherto been assigned to a marginal status.

This vignette is offered not to dispute or assert the correctness of any particular understanding of mental distress over another but rather to suggest that when a group of meanings become privileged they are invested with a status of truth and knowledge, thus alternative perspectives that do not fit with the privileged model are suppressed. According to Foucault (1995 pxiii); "the language of psychiatry, which is a monologue of reason about madness, has been

established only on the basis of such a silence." This process of suppression happens in most areas of life and is often unchallenged, but in mental health nursing where finding meaning in experiences is one of the prime motivations of mental health nurses and people in care, such unchallenged, one dimensional assumptions can be problematic. The scenario presented here, and many others like it, demonstrates the difficulty for nurses in configuring the inner voices of their personal gendered experiences, beliefs, history and culture and their interactions with people in care with prevailing "explanatory" and prescriptive frameworks.

## The Voice(s) of the Person in Care

Many of the challenges facing nurses also confront the person who is experiencing mental health problems; the desire to order confusion, alleviate pain and gain personal knowledge and mastery. People in mental pain and distress may be attempting to make sense of multiple voices, such as unusual overwhelming voices in their heads (England 2007, Leudar and Thomas 2000), their inner voices of negativity and fear (Jones 1999), and the voices, expectations and sometimes censure of family and society (Sayce 2000). Like nurses, people with mental health problems construct meaning in these experiences incorporating a range of influences and explanatory frameworks. For example, some people with mental health problems find biomedical explanations of their distress useful as they perceive that they are experiencing an illness or disease and take comfort in the ability of trained mental health professionals to help them (Hinton and Levkoff 1999). Brown at al (1996 p1578) claim that "clients' descriptions of their problems are already storied along psychiatric lines." For others, such explanations are unhelpful. The mental dis-order may be viewed as spiritual in nature; spirits are communicating through them, perhaps punishing them for past deeds or they perceive themselves to be in spiritual crisis which needs to be resolved through spiritual means (Wilding et al 2006). Carone and Barone (2001 p989) state that "religious beliefs provide order and understanding to an otherwise chaotic and unpredictable world." Other people believe that their distress is a manifestation of personal, familial, cultural crisis and that healing / recovery needs to be achieved at this level (Champ 1999, Sarason and Duck 2000). Some people who come into mental health services may not believe that they have any inner mental health issues but rather are being distressed by external forces (Leudar and Thomas 2000). Some of these explanatory frameworks may sustain a positive conception of self and the world and aid recovery while some may be unhelpful to the person in moving beyond distress.

People in mental distress bring their stories and performances to mental health nurses as well as their expectations and hopes for how the nurse can help them. These expectations will be shaped by societal discourses as well as the person's previous experiences of nurses and mental health care. Crowe (2000) argues that there is hierarchical differentiation in many mental health care relationships; the person with mental health concerns is positioned as a 'patient', the person asking for help and therefore less powerful than the care-giver. She further claims that nurses and patients are expected to interact in predictable ways with each other, the nurse, as competent practitioner guiding the intervention and the patient amenable to the nurse's interventions. This hierarchical differentiation and appropriation of power through "knowledge" or "expertise" has come under increasing challenge in contemporary mental health care contexts. Information technology, improved mental health awareness among the general public and the rise of service user and recovery movements with their accompanying critique of privileged constructions of mental disorder and mental health practices are gaining voice (Lindlow 1996, Bee et al 2008). This means that many people experiencing mental health issues are more likely to pursue dialogue around the nature of their distress rather than appropriating dominant discourses to account for their experiences (Barker et al 1999). In contemporary mental health nursing, much work has been done to challenge disempowering constructions of mental distress and treatment (Warne and McAndrew 2007, Barry 2007). The philosophies of poststructuralist thinkers such as Foucault (1980, 1995) have helped nurses to recognize and deconstruct some dominant discourses of knowledge and power that operate within the field and to develop ways of exploring and interacting with the experiences of people in mental pain in ways that respect and therapeutically integrate the person's perceptions and strengths (Shanley and Jubb-Shanley 2007, Crowe et al 2008).

Discourses of power and privilege resound in many interactions between the person in care and the nurse; these are rarely acknowledged and dismantled within the interaction. However, in the following vignette the service user challenges these subject positions and taken for granted interpretations of his situation. The extract presented here is taken from a larger research study conducted by one of the authors (Casey and Long 2002). That study explored the narratives of mental health services users in relation to their understandings of their mental distress. This conversation occurred between David (D), a research participant and mental health service user, and the researcher (B) who identified herself to David as a nurse teacher.

D: Well, what happened to me?  I believe it came back to teenage years.  My recollection is that within the family until the age of about ten or eleven I felt secure and happy.

B: O K.

D: But then when it came to teenage years there was just a blank wall in front of me.  Nobody talked to me about teenage years, nobody used to talk about teenage years, in fact it was the reverse, nobody wished to talk about it at all, and I was really wanting to know about what was happening my body and what was happening me but there was no, including doctors, they never talked about the teenage years at all.  And I believe they're critical to my own personal development.

B: Right.

D: But they were never talked about.  Even to this day I asked for talk therapy with a doctor or some social worker and the chance of me getting it are very slim.  And I read about a survey that was carried out on four thousand six hundred patients or service users who take tablets in England and they said that the worst tablet they take is Haloperidol, that's the worst from the user's point of view…But nobody has talked to me intimately about the drug and its effects on the personality.  And you're a tutor and I'm sure you tell your nurses the truth about the drug but you don't tell the users that truth, you see I don't think you do, you can correct me on this by saying do you tell the users what the drug does to them by how does it affect them sexually and things like that and it does have a big effect sexually on people?

B: Yeah, it does.

D: But no one does talk about it.  It's just a blind wall you come up against and I'm not being helped by it and yet I'm still on the drug and if I get a little bit annoyed why I'm on the drug it's taken as symptoms not natural annoyance why I'm still on the drug…What would you say are the effects of the drug?

B: Well….

D: On you sexually

B: Well, it's well known that the drug…

D: I don't know it! I don't know it! I mean you can tell me now with that microphone on what are the effects that it has sexually on the person.  Can you tell me that?

B: Yeah…well the effects that it can have sexually are that it can dampen down people's sexual responses.

D: Dampen down?   It takes them away completely….takes them away completely and that was the area in which my problem was in the first place…and look at where I am now.  But the doctors didn't do anything to

help me, all they did was pump tablets into me and give me injections and to this very day I'm talking to you, a tutor and you're not helping me very much either, you're listening to me for your degree or for your diploma and nothing will come of this tape that will help me but it will help you.

B: Well that's fair enough David, if you don't want to….

D: It's not fair enough with me, I'd like something to be done about my predicament and I'd like to get talking.  I'd like someone to talk to me about my predicament, not always to be giving me injections and tablets.  Talk, they said it in the survey that was done in England about four thousand six hundred users, most of them thought talk therapy was very successful and highly recommend it.  I never got it.

B:Hmmm

D The doctors were all hoity toity up on their high horses, looking down on me and asking me questions and then shutting up and making me feel nervous, they didn't accommodate me at all.  And em I feel myself that I will not get talk therapy at all because I'm afraid of doctors and I don't talk too well to them due to my past experiences of them; that's only natural that I should be afraid of them 'cause they wielded their authority without bringing me into their confidence.

In this interaction, many voices resonate and contend with each other.  David expresses his anger and bitterness as he claims the validity of his personal understandings against the 'authority' of the professionals he encountered.  In his story one can also hear his grief at lost opportunities, sadness and isolation as he is excluded, not brought "into their confidence."  Perhaps his request for "talk therapy" is also a request for dialogue that is meaningful and acknowledging of him as an intelligent man with sexual needs.  David presents his knowledge of service user research to help him articulate his anger and distrust of a system that he believes has rendered him voiceless.  He positions the researcher as a representative of that system, part of that secret exclusive club, present with tape recorder gathering information for personal study purposes.

This encounter evoked personal responses in the researcher such as sadness for David, as well as guilt on behalf of a system that he perceived to have caused him so much damage.  She also felt frustrated and hurt that he viewed her as part of his oppression; like the doctors getting information, diagnosing and medicating, claiming that things which are not explained are common knowledge.  The researcher might share many of his criticisms but because of her position as representative of the health care system felt "duty bound" not to articulate these opinions and thus was also silenced.

The researcher's response, reflected in her comment "Well that's fair enough David, if you don't want to…." reflects her anger at David for bringing these issues into consciousness and positioning her in this way. David's challenges evoked in the researcher feelings of impotence sometimes experienced in the 'caring' role and often resulting in the nurse adopting an authoritative and defensive position. Experiences of transference and counter transference, the most primitive and personal voices in our dialogues, abound in interactions such as these and result in participants shifting positions and power balances. According to Hammarström (2008 p169) "power can be seen as something that is created and that shifts between the interviewer and the interviewed." David scathingly counters "It's not fair enough with me…" thus highlighting his perception of the injustice and inequality of the interaction which reflected his relationship with the health care system.

In addition to the intrapersonal struggle within the interaction, simultaneously external dialogues were contending for dominance; for example the authority claims made by service user research presented by David and the possible psychiatric or "therapeutic" interpretations of David's narrative and articulation of distress available to the researcher. The researcher felt compelled to tick off "psychiatric symptom boxes;" mentally noting, as David related his experiences and opinions, his "pressure of speech," and possible "paranoid delusions." She could also hear such authoritative labels as "narcissistic personality disorder", "skewed family dynamics" and "repressed sexual disorder." Holland et al (2003 p15) comment on the implications of this dialogical wrestling:

> Dialogic perspectives such as Bakhtin's (1981) explicitly free us from the idea that we as a group or as individuals can hold only one perspective at a time. Humans are both blessed and cursed by their dialogic nature - their tendency to encompass a number of views in virtual simultaneity and tension, regardless of their logical incompatibility.

This vignette is offered as an example of the complexity of the interaction that can occur when multiple competing dialogues come into play for the nurse and the person in care. How can the nurse make sense of interactions such as this? How can these personal reactions and professional discourses be configured with the meanings that David is trying to articulate? It can be tempting to allow professional explanatory discourse to dominate; David's mental illness means that his perceptions and judgments may be 'irrational' and therefore less credible. It can be claimed that he lacks insight into his condition. This approach offers an approved systematic framework of constructing David's story that overshadows both David's and the researcher's troubling voices. Indeed, David refers to this,

perhaps customary, professional response when he claims that demonstrating his annoyance about his treatment would be constructed as symptomatic thereby invalidating him and his views further.  Roberts (2005 p 33), in an examination of Foucault's writing, observes that "power and knowledge are central to the process by which human beings are 'made subjects' and therefore how 'psychiatric identities' are produced."

When one considers the limitations of such interchange it becomes clear that alternative ways must be found to more effectively manage such interactional impasses.  These ways involve being open to hearing all voices in the dialogue and sitting with the tensions that can sometimes occur in these interactions. Through exploring these points of discomfort and colliding discourses the nurse can achieve more sophisticated understandings of the context and needs of people in care.

## Reconciling Multiple Voices

The mental health nurse, given her / his central place in the multidisciplinary team and having opportunities for extended contact with the person experiencing mental pain, is in a prime position to influence mental health care practices in significant ways.  Some of the challenges associated with including marginalized discourses and integrating competing monologues have been demonstrated in the case vignettes above.  These vignettes also demonstrated how the mental health nurse can sometimes close the self off to alternative ways of perceiving and acting in the world.  Many writers have considered how and why this closing off takes place.  For example Menzies-Lyth's seminal work in the 1950's (Menzies-Lyth 1988), and others since (Lakeman 2006, Evans et al 2008, Tognazzini et al 2008), have observed defensive reactions and the investment in routinised tasks as a form of protection against the anxiety inherent in the professional and interactional work of nursing.  Foucault (1980) posits that the power that is invested in dominant discourses and knowledges means that people working in these systems relinquish some of their own agency and contradictory beliefs.  Richardson (2000 p517) claims that we are "homogenized" through professional socialization and that through this process our own personal perceptions and understandings are suppressed.  Eventually, adherence to the established order leads to habitus, which involves adoption of traditional taken for granted practices viewed as "common sense" and therefore unquestioned in terms of their validity.  Jones (2005 p1177) claims that unlike other professional therapeutic groups, nursing does not have a 'culture' of personal therapy, which facilitates personal and professional critique

and development, thus nurses "…are potentially denied opportunities to understand aspects of their unresolved struggles."

Challenging taken-for-granted discourses and traditions may involve risk taking and can be anxiety provoking as hitherto widely accepted practices and perspectives are contested. Therefore, the nurse needs to be able to call upon her / his personal and professional resources in such challenging situations in order to ensure that communication, which is a central component of the mental health nurse's role, remains as constructive as possible. Two interlinked communication strategies; cultivating a disposition of 'curiosity' (Cecchin 1987), and creating 'dialogic space' (Anderson & Goolishian 1992) are proposed as key elements in managing the tensions between contending dialogues. Each of these will be discussed further in the following sections.

## A Disposition of Curiosity

Within therapeutic practice a tension exists between a desire to explore the lived experiences of the other, and an orientation towards capturing that experience, defining it and making it amenable to therapeutic intervention. Nurses are acutely aware of the importance of collating objective data, such as the psychiatric history and observable signs and symptoms of mental dis-order in order to make accurate assessments and formulate relevant care plans. This impetus is based on the premise that mental distress can be observed, explained, defined and categorized and then treated on the basis of this assessment activity. While this model provides direction for the nurse, the person's lived experiences of mental distress can sometimes be lost to the realm of the incidental, as the preconceived medical / nursing discourse is privileged. This undermines genuine interest in the individual's story as exemplified in David's story above. An alternative perspective is to be able to accept and live with a degree of ambiguity and uncertainty, challenging the idea that there exists a single objective reality and absolute truth and accepting that sometimes it will be difficult to grasp meanings of experiences and / or to facilitate this meaning making with others. This approach has been referred to as 'curiosity', or a kind of open-mindedness regarding the process and outcome of communication, the unique story of the other, and the emergence of unanticipated views and moves (Cecchin 1987). According to Cecchin (1987), when this curiosity is suppressed, it can hinder the practitioner from genuine engagement with the person's unique story and from considering the multiple possible ways forward. An attitude of curiosity presupposes preparedness to learn and to be surprised and welcoming in relation to all dialogues encountered. Stimulating and sustaining curiosity and preventing dominance of predetermined professional monologues at the expense of the

individual perspective, involves a heightened level of self awareness in the nurse. It is suggested that self awareness is a prerequisite for reflective and ethical practice (Peplau 1952, Jack and Miller 2008). Within the nursing profession reflective practice, which promotes self awareness and self insight, has long been recognised as an essential tool in the interactive process (Schon 1983, Fejes, 2008, Crowe and O Malley 2006). The nurse must examine and address her / his own internal voices; assumptions, biases and potential for closing off dialogue. (Hammarström 2008). According to Jones (1999 p826):

> "Listening to others requires the ability to listen to one's own inner voices and recognize how they might guide exchanges. By avoiding conducting conversations in ways dictated by our own fears, worries and fantasies we can listen, and in doing so allow shifts in awareness."

As Crowe (1998 p87) puts it: "Nurses need to be able to acknowledge how their experiences have influenced who they are and how they interact before they can use their self and their skills to help others." This process involves the nurse recognising and acknowledging her / his own embedded fixed beliefs that possibly constrain understanding of and engagment with alternative narratives. The nurse develops the ability to critically examine and de-construct the dialogues and discourses in which s / he is enmeshed (Collier 2008) as well as seeking out and engaging with those that offer possible alternative ways of understanding mental pain and helping people in mental distress (Stickley and Timmons 2007). Some writers argue that not only will this openness and exploration facilitate enriched engagement and dialogue with people in care but it will also foster a heightened level of empowerment within the nurse (Udod 2008) as s / he "adopt(s) a more critical stance to understanding power and empowerment in nursing" (Bradbury-Jones et al 2008 p258).

Thus, cultivating a disposition of curiosity that promotes reflection offers a systematic way of reviewing and critiquing one's practice. This enables identification of unforeseen possibilities for engagement in dialogue and considered anticipation of potential challenges and barriers to forward movement, enhancing curious engagement with self and other. This critical process makes it possible for the practitioner to remain in the tension between opposing monologues in order to create dialogic space.

## Creating Dialogic Space

It has been suggested that one of the central challenges in overcoming therapeutic impasse is to be able to remain in the tension between opposing

monologues, thereby unpacking the contribution of different perspectives in addition to accommodating hitherto unforeseen common ground, in purpose if not perspective (Rober 1999). Such an endeavor is built upon openness to different perspectives and courses of action, a curiosity about the views and experiences of the other, and the courage to not only tolerate and accept diversity but to invite it and celebrate its potential for learning. This position does not suggest that the mental health nurse is without or abandons her / his expertise, personal and professional, that can usefully contribute to the alleviation of mental distress. Rather it suggests that s / he use this expertise informatively, rather that impositionally, with the person in care (Anderson and Goolishian 1992). Sharing one's expertise in this way challenges the traditional view of the 'expert' knower, who holds knowledge that is fixed and superior to other knowledges. Instead it suggests that the nurse's knowledge is evolving and held as one knowledge among multiple ways of knowing.

Thus, the expert nurse is an expert in creating and managing dialogic space and the tension within this rather than being a problem solver who must avoid or resolve such inevitable tensions. S / he is aware that integration of different conversational voices may not only be impossible at times but it may indeed not be desirable for her / him to seek reconcilation of voices when remaining in the tension between these affords greater opportunity for creativity in interaction. This requires that the nurse develop confidence and trust in the unpredictable sense making dynamics occurring in the therapeutic encounter. S / he creates a dialogic space with the person in interaction; inviting people in care to influence her / his own and others understandings and knowledge regarding the experience of mental distress (Houghton et al 2006, Shanley and Jubb-Shanley 2007, Crowe et al 2008). Thus, creating dialogical space demands greater attention to what the person in care construes as meaningful and helpful to them in their unique situation.

## Conclusion

There are times when the multiple voices in the mental health domain converge into a rich interchange where negotiation of meanings occurs leading to deeper perspectives that provide new opportunities for action. When this dialogic exchange takes place the contributors experience a sense of both inclusion, in terms of their own voice being valued, and transposition whereby they can appreciate and understand the positions and contributions of the other. However, mental health nurses and people in care often experience discordance or imbalance of voices within interactions which, if not recognized and addressed by

the nurse in the therapeutic encounter, can lead to withdrawal or stagnation within the relationship.

Thus, within mental health practice the importance of developing an ability to critically examine and de-construct the discourses in which one is embedded, that are possibly constraining to the development of understandings of and engagement with alternative versions of reality, is deemed essential to therapeutic interaction. For example, seeking out and engaging with varying approaches to understanding mental pain and helping people in mental distress.

Within nursing it has been proposed that reflective processes, enhanced by clinical supervision / consultation, facilitate the nurse in incorporating multiple perspectives and engaging openly and creatively in the interactive process. In assisting the nurse to move to a more liberating place in her interactions with self and other, some possible strategies have been proposed for managing this dialogic tension. Such proposals incorporate two interlinked processes, the nurse cultivating curiosity in the multiple perspectives that surround her in daily therapeutic practice (Cecchin, 1987), and creating space for dialogue by reflexively and therapeutically utilising the tension between inner and outer voices to enhance transformative opportunites for self and other.

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